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In the second group there belong mania with agitation, simple stupor, and the insanity of persecution. In these cases, in fact, apart from a certain degree of muscular hyperexcitability and a slight amount of hyperæsthesia, the symptomatology is similar to that of normal urine, the enfeeblement and the prostration simply being more marked.

In the first group belong mania through nutritional troubles, melancholic stupor and melancholia. The cases of mania of this group show a hyperæsthesia, a muscular and auditory hyperexcitability, and a state of convulsibility that is not found with normal urine.

In cases where the pathological urine only reproduces the symptoms of intoxication by normal urine the degree of toxicity is closely connected to the greater or less intensity of the disease. In mania it is associated with the agitation, in stupor to the depression. When, on the contrary, the pathological urine gives rise to new symptoms, the toxicity persists in its principal characteristics, although the intensity of the disease has diminished, and only disappears when the individual has completely recovered his normal state. Consequently, while in the first case the toxicity of the urine is associated, not to the cause of the disease itself, but a secondary element—the acuteness, in the second case it is intimately associated with the disease itself. There is thus an essential difference between the diseases of the second group and those of the first. Studying these two groups from the etiological point of view, the causes may be divided into two groups: the ordinary causes of the neuroses, and secondly, such causes as infectious diseases, the puerperal state, puberty, etc.

Associating these etiological facts with those obtained from experimentation, it is seen that those cases which have as causes the ordinary causes of the neuroses, are those in which the toxicity of the urine is allied to a secondary element, agitation or depression, while those which are caused by a profound mental trouble are the cases in which the toxicity of the urine appears to be allied to the cause of the disease itself. Experimentation, therefore, appears to confirm that which is indicated by the study of the causes, and to show the existence, in addition to the neurotic mental alienations, of mental affections of another character. Experiments, however, do not warrant us in going farther and determining the exact nature of these mental alienations. It is of little consequence what physical cause has given rise to the insanity, the puerperal state or infectious diseases, the urines always produce the same toxic phenomena. Consequently, it is not to the typhoid or puerperal poison, for example, that it is necessary to assign the mental alienation, but to some other element common to all these perturbations, and as the sole common element is the trouble brought on by nutritive disturbance, we are forced to assign these mental alienations to this trouble. Consequently, in addition to nervous mental affections, a place should be assigned to *mental affections through troubles of nutrition*. The experiments, therefore, appear to the authors to have a double interest. (1) They confirm scientifically the opinion that certain physical disturbances may give rise to mental alienation. (2) They unite in the same group, *mental alienation through troubles of nutrition*, the mental alienations studied by authors under the different names which have been the causes capable of producing them: puerperal insanity, insanity of pubescence, etc.

FOLSOM, *Some points regarding general paralysis*, Boston Med. and Surg. Journal, Sept. 3, 1891.

Of the many divisions of general paralysis into several clinical types, all of them naturally more or less arbitrary, Folsom considers Meynert's

eight the most satisfactory (*Klinische Vorlesungen über Psychiatrie, Wien, 1890, Braumüller*).

(1) Simple progressive dementia, with the usual progressive motor impairment which accompanies it.

(2) With delusions of grandeur and with marked motor disturbances, which appear simultaneously and are progressive. The mental state is usually of exaltation, but there may be depression.

(3) Of the same type as the last, but failing its steadily progressive character, that is, with remissions.

(4) Cases in which the characteristic exaltation and grand delusions reach such an astonishing height that the manifest motor symptoms are looked for with confidence from day to day, and yet may not appear even for a year, any slight incoördination naturally being obscured by the general muscular disturbance. Meanwhile there may be such an improvement as to simulate a recovery.

(5) A very rare form with alternate symptoms of exaltation and depression.

(6) With early furious delirium, painful hallucinations, confusion and incoherence somewhat resembling acute delirium.

(7) In which the characteristic indications appear secondary to other forms of insanity, for instance, after paranoia or melancholia.

(8) The combined form, with sclerosis in the whole cerebro-spinal tract, the symptoms of tabes or spastic paralysis predominating, according as the posterior or lateral columns of the cord are chiefly involved. The ascending type, in which the cord is first affected, is rare. Optic neuritis, ending in atrophy and paralysis, especially of the ocular muscles, may precede marked mental symptoms.

In Paris in 1874, and chiefly by Sander in Berlin in 1876, attention was called to a period in general paralysis in which there are vague signs of mental failure for a varying length of time, perhaps for several years antedating the pronounced symptoms. This early stage is most marked in Meynert's first class, the demented type, to which the recent great increase in general paralysis belongs.

Of the different pathological designations of the disease, chronic meningo-encephalitis, chronic diffuse periencephalitis, Folsom prefers chronic diffuse cortical encephalitis, whether primarily interstitial or parenchymatous, ending in greater atrophy than occurs in any other form of insanity. For the microscopic changes found in the cortex the description of Mendel is quoted (reviewed in this Journal, III. p. 560).

Folsom calls attention to the fact that the post-specific cases, with a previous history of specific disease not recent, those not only not benefited by iodides and mercury, but usually debilitated and injured by them, may exhibit post-mortem the same microscopic changes as those in which there is no ascertained evidence of syphilis. In paralytic dementia, with a recent history of syphilis also, and with marked indications of specific disease, where anti-syphilitic remedies avail to produce such an amelioration of symptoms as to simulate a cure at least for a time, the same diffuse cortical changes may be found at the autopsy-points, which, in making and verifying diagnoses, should be borne in mind as well as the facts that there are degenerative changes in the brain secondary to gross syphilitic lesions, which do not constitute general paralysis, and that the several types of general paralysis and other conditions of cerebral atrophy exhibit post-mortem appearances which may so gradually shade off into each other as to make the analogy very close. In senile and chronic simple insanity, the atrophy of the nerve fibres is primary, while in paralytic dementia the essential process, according to Obersteiner, is a diffuse primary sclerosis of the cortex, which leads to atrophy, which appears in the frontal lobes first. Folsom follows Obersteiner's view that the sclerosis is preceded

by a condition of irritation which seems to justify the expression, chronic periencephalitis, although the brain-coverings play only a secondary rôle. Obersteiner's views that the "spider cells" are formed from wandering leucocytes, are quoted, together with his description of the processes leading to fibre-atrophy. Healthy and diseased cells and fibres being seen side by side, the early symptoms do not constitute a paralysis, but a cortical ataxia, a motor intelligence-disturbance on the one hand, and on the psychic side mental failure due to defective association of ideas through greater or less affection of the association-fibres of the cortex. Further than that we can scarcely yet be said to know much about the relations of pathological conditions to abnormal mental manifestations in general paralysis, except so far as the final atrophy explains the intellectual and physical decay. Folsom's description of the prodromal stage of general paralysis has already been reviewed in this Journal (Vol. III. p. 557).

CUYLITS, *Surmenage et folie paralytique*, Bulletin de la Société de Médecine mentale de Belgique 1890 p. 271.

In this article the author attempts to make good his assertion that overwork, traumatism, the abuse of alcohol and tobacco produce no bad effect in a sane man. They may produce some form of mental alienation in a nervous hereditary subject; they may produce general paralysis when this hereditarily predisposed subject is syphilitic from birth or when he becomes so later. In assigning this specific origin to general paralysis he classes it with the diseases by intoxication of the same kind as the nervous accidents due to typhoid fever or diphtheria. The author urges that it is not easy to demonstrate by facts and arguments that overwork may of itself be able to cause general paralysis. He thinks that if a particular case is cited as a case of general paralysis from overwork that, unhappily for the demonstration, it would be difficult to establish the fact that he was not at the same time an hereditary subject, and on this account the observation would be without value. The contention of the author is that the normally endowed man cannot overwork, fatigue acting as a sort of safety valve, producing sleep in time to save the brain. If a man, apparently sound and healthy, with no sign of degeneration, overworks and becomes insane, he is *ipso facto* a degenerate, else he would not have broken down, and you have not looked deep enough for the signs of degeneration. Criticism is simply powerless before such an argument.

CHEVALIER, *La paralysie générale à l'asile de Dijon* (de 1843 à 1889), Thèse de Bordeaux 1889-1890 No. 52.

From a statistical study of the records of the Dijon Asylum, Chevalier concludes:

1. The number of general paralytics has risen during 30 years from 13% to 20% for the men, and from 5% to 7% for the women.
2. The proportion is four times greater among the men than among the women.
3. The number of married paralytics is double that of the unmarried.
4. The average age is 38 years for the men and 40 years for the women.
5. There were no paralytics under 21 years.
6. From 20 to 25 the proportion is 1-5%.
7. The laboring class furnished about 30% of the number of paralytics; the commercial and industrial classes 25%; the liberal professions 5% (Dijon is a public asylum).
8. Among 163 paralytics whose hereditary and personal antecedents were established, there were 1-5 with an alcoholic heredity; 1-5 with a congestive and insane heredity; 1-13 with a history of syphilis.